

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Albert 12914 CERTIFICATE OF DEATH

12907 51
100

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Prince Frederick's</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>md</i> b. COUNTY <i>Charles</i> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Prison</i> 08X1.2			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>90 Prince Frederick Nursing Home</i>				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First Middle Last <i>Marcellus BOWIE</i>				4. DATE OF DEATH Month Day Year <i>12 - 16 1957</i>			
5. SEX <i>Male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>March 24, 1875</i>	9. AGE (In years last birthday) yrs. <i>82</i>	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>1 Peter Bernheimer</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>Lumber</i>		11. BIRTHPLACE (State or foreign country) <i>Pirgah Md</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>							
13. FATHER'S NAME <i>John T Bowie</i>				14. MOTHER'S MAIDEN NAME <i>Susie Posey</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>no</i>				16. SOCIAL SECURITY NO.			
17. INFORMANT <i>Aubrey Bowie</i>				Address <i>Prison Md</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>334x Uremia + Cerebral Arteriosclerosis</i> DUE TO (b) <i>Generalized Arteriosclerosis</i> DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <i>July</i> , 1957, to <i>Dec 16</i> , 1957, that I last saw the deceased alive on <i>Dec 15</i> , 1957, and that death occurred at <i>9 A.M.</i> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>Page Jett</i>				DATE SIGNED <i>Prince Frederick</i>			
PHYSICIAN'S NAME (Type) <i>PAGE C. JETT M.D.</i>				<i>PRINCE FREDERICK</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <i>12-19-57</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Pirgah M.E.</i>		22d. LOCATION (City, town, or county) (State) <i>Pirgah Md</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Archie L. LaPlata</i>				24. REC'D BY REGISTRAR <i>12/17/57</i>		24b. REGISTRAR'S SIGNATURE <i>Julia H. Hays</i>	

12915 CERTIFICATE OF DEATH

12908

Reg. Dist. No. 51

1. PLACE OF DEATH a. COUNTY <u>Calvert</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Calvert</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Husley</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x2 Husley</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>1</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Thomas</u> Middle <u>W</u> Last <u>Brooks</u>				4. DATE OF DEATH Month <u>12</u> Day <u>18</u> Year <u>1957</u>			
5. SEX <u>m</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 2</u>		9. AGE (In years last birthday) <u>65</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>John Brooks</u>				14. MOTHER'S MAIDEN NAME <u>Hennette Tyler</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>216-22-234</u>		17. INFORMANT <u>Maud Brooks</u>		Address <u>Husley Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart failure -</u> <u>241X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary atherosclerosis -</u> DUE TO (c) <u>Asthma -</u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Dec 17</u> , 19 <u>57</u> , to <u>Dec 18</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Dec 17</u> , 19 <u>57</u> , and that death occurred at <u>6:30</u> P.M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>R. E. Seavele</u> M.D.				DATE SIGNED <u>12/19</u>			
PHYSICIAN'S NAME (Type) <u>R. E. Seavele</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>12-22-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St Johns</u>		22d. LOCATION (City, town, or county) (State) <u>Lower Marlboro Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>P. E. Seavele</u> ADDRESS <u>Prince Fred, Md</u>				24a. REC'D BY REGISTRAR DATE <u>12/23/57</u>		24b. REGISTRAR'S SIGNATURE <u>H. W. Ward</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Page No. 10

<p>1. NAME OF DECEASED</p>		<p>2. SEX</p>		<p>3. AGE</p>		<p>4. DATE OF BIRTH</p>		<p>5. PLACE OF BIRTH</p>	
<p>6. OCCUPATION</p>		<p>7. CAUSE OF DEATH</p>		<p>8. MANNER OF DEATH</p>		<p>9. DATE OF DEATH</p>		<p>10. PLACE OF DEATH</p>	
<p>11. SIGNATURE OF PHYSICIAN</p>		<p>12. SIGNATURE OF CORONER</p>		<p>13. SIGNATURE OF JURY</p>		<p>14. SIGNATURE OF DECEASED</p>		<p>15. SIGNATURE OF WITNESSES</p>	
<p>16. SIGNATURE OF DECEASED</p>		<p>17. SIGNATURE OF WITNESSES</p>		<p>18. SIGNATURE OF DECEASED</p>		<p>19. SIGNATURE OF WITNESSES</p>		<p>20. SIGNATURE OF DECEASED</p>	
<p>21. SIGNATURE OF WITNESSES</p>		<p>22. SIGNATURE OF DECEASED</p>		<p>23. SIGNATURE OF WITNESSES</p>		<p>24. SIGNATURE OF DECEASED</p>		<p>25. SIGNATURE OF WITNESSES</p>	
<p>26. SIGNATURE OF DECEASED</p>		<p>27. SIGNATURE OF WITNESSES</p>		<p>28. SIGNATURE OF DECEASED</p>		<p>29. SIGNATURE OF WITNESSES</p>		<p>30. SIGNATURE OF DECEASED</p>	
<p>31. SIGNATURE OF WITNESSES</p>		<p>32. SIGNATURE OF DECEASED</p>		<p>33. SIGNATURE OF WITNESSES</p>		<p>34. SIGNATURE OF DECEASED</p>		<p>35. SIGNATURE OF WITNESSES</p>	
<p>36. SIGNATURE OF DECEASED</p>		<p>37. SIGNATURE OF WITNESSES</p>		<p>38. SIGNATURE OF DECEASED</p>		<p>39. SIGNATURE OF WITNESSES</p>		<p>40. SIGNATURE OF DECEASED</p>	
<p>41. SIGNATURE OF WITNESSES</p>		<p>42. SIGNATURE OF DECEASED</p>		<p>43. SIGNATURE OF WITNESSES</p>		<p>44. SIGNATURE OF DECEASED</p>		<p>45. SIGNATURE OF WITNESSES</p>	
<p>46. SIGNATURE OF DECEASED</p>		<p>47. SIGNATURE OF WITNESSES</p>		<p>48. SIGNATURE OF DECEASED</p>		<p>49. SIGNATURE OF WITNESSES</p>		<p>50. SIGNATURE OF DECEASED</p>	
<p>51. SIGNATURE OF WITNESSES</p>		<p>52. SIGNATURE OF DECEASED</p>		<p>53. SIGNATURE OF WITNESSES</p>		<p>54. SIGNATURE OF DECEASED</p>		<p>55. SIGNATURE OF WITNESSES</p>	
<p>56. SIGNATURE OF DECEASED</p>		<p>57. SIGNATURE OF WITNESSES</p>		<p>58. SIGNATURE OF DECEASED</p>		<p>59. SIGNATURE OF WITNESSES</p>		<p>60. SIGNATURE OF DECEASED</p>	
<p>61. SIGNATURE OF WITNESSES</p>		<p>62. SIGNATURE OF DECEASED</p>		<p>63. SIGNATURE OF WITNESSES</p>		<p>64. SIGNATURE OF DECEASED</p>		<p>65. SIGNATURE OF WITNESSES</p>	
<p>66. SIGNATURE OF DECEASED</p>		<p>67. SIGNATURE OF WITNESSES</p>		<p>68. SIGNATURE OF DECEASED</p>		<p>69. SIGNATURE OF WITNESSES</p>		<p>70. SIGNATURE OF DECEASED</p>	
<p>71. SIGNATURE OF WITNESSES</p>		<p>72. SIGNATURE OF DECEASED</p>		<p>73. SIGNATURE OF WITNESSES</p>		<p>74. SIGNATURE OF DECEASED</p>		<p>75. SIGNATURE OF WITNESSES</p>	
<p>76. SIGNATURE OF DECEASED</p>		<p>77. SIGNATURE OF WITNESSES</p>		<p>78. SIGNATURE OF DECEASED</p>		<p>79. SIGNATURE OF WITNESSES</p>		<p>80. SIGNATURE OF DECEASED</p>	
<p>81. SIGNATURE OF WITNESSES</p>		<p>82. SIGNATURE OF DECEASED</p>		<p>83. SIGNATURE OF WITNESSES</p>		<p>84. SIGNATURE OF DECEASED</p>		<p>85. SIGNATURE OF WITNESSES</p>	
<p>86. SIGNATURE OF DECEASED</p>		<p>87. SIGNATURE OF WITNESSES</p>		<p>88. SIGNATURE OF DECEASED</p>		<p>89. SIGNATURE OF WITNESSES</p>		<p>90. SIGNATURE OF DECEASED</p>	
<p>91. SIGNATURE OF WITNESSES</p>		<p>92. SIGNATURE OF DECEASED</p>		<p>93. SIGNATURE OF WITNESSES</p>		<p>94. SIGNATURE OF DECEASED</p>		<p>95. SIGNATURE OF WITNESSES</p>	
<p>96. SIGNATURE OF DECEASED</p>		<p>97. SIGNATURE OF WITNESSES</p>		<p>98. SIGNATURE OF DECEASED</p>		<p>99. SIGNATURE OF WITNESSES</p>		<p>100. SIGNATURE OF DECEASED</p>	

BUREAU V. 3

DEC 26 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12909 51

12916 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Calvert MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Calvert			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Prince Frederick				c. LENGTH OF STAY IN 1b 2 Days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Calvert Co., Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Adela Middle Credan Last Credan				4. DATE OF DEATH Month Dec. Day 15 Year 19 57			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct., 10, 1882		9. AGE (In years last birthday) 75 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Washington D.C.	
13. FATHER'S NAME Charles Demonet				14. MOTHER'S MAIDEN NAME Mary Ann Clark			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Address Beach Md. Mrs. Ann Carey-Friend Chesapeake	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized arterio-sclerosis DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Dec 1 , 19 57 , to Dec 15 , 19 57 , that I last saw the deceased alive on Dec 15 , 19 57 , and that death occurred at M , from the causes and on the date stated above. ACTUAL SIGNATURE Roberto De Vallarreal M.D. ADDRESS (Street, city or town, state) St Leonard, Md DATE SIGNED 12/16/57							
PHYSICIAN'S NAME (Type) Dr. Roberto De Vallarreal							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-18-57		22c. NAME OF CEMETERY OR CREMATORY Oak Hill		22d. LOCATION (City, town, or county) (State) Washington D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE J. Wm. Lee Funeral Home				ADDRESS 300 4th ST N.E.		24a. REC'D BY REGISTRAR DEC 19 1957	
				24b. REGISTRAR'S SIGNATURE Hugh King			

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

DEC 19 1957

RECEIVED

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12917 CERTIFICATE OF DEATH

12910

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Calvert</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Calvert</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Huntingtown</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X1 Huntingtown</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>W</u> Last <u>Chase</u>				4. DATE OF DEATH Month <u>Dec.</u> Day <u>2</u> Year <u>1957</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 9</u>	9. AGE (In years last birthday) <u>85</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John W. Chase Sr.</u>				14. MOTHER'S MAIDEN NAME <u>Matilda Kent</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Eugene Chase Huntingtown</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1 Coronary occlusion</u> DUE TO (b) <u>Generalized arterio-sclerosis</u> DUE TO (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>11/20</u> , 19 <u>57</u> , to <u>12-2</u> , 19 <u>57</u> that I last saw the deceased alive on <u>12/2</u> , 19 <u>57</u> , and that death occurred at <u>12 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Rowell</u> M.D.				ADDRESS (Street, city or town, state) <u>St. Leonard, Md.</u> DATE SIGNED <u>12/5/57</u>			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>Dec. 5, 57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Youngs Chapel</u>		22d. LOCATION (City, town, or county) (State) <u>Huntingtown Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>P. E. Sewell, Prince Fred, Md</u> ADDRESS				24a. REC'D BY REGISTRAR <u>DATE 12/9/57</u>		24b. REGISTRAR'S SIGNATURE <u>H. W. Ward</u>	

DEC 11 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12911

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Calvert</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Stevie</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Calvert Co. H</u>		2. USUAL RESIDENCE (Where deceased lived. If Institution, Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Calvert</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Stevie</u> d. STREET ADDRESS <u>XO 1</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Raymond</u> First <u>Orvin</u> Middle <u>Fletcher</u> 4. DATE OF DEATH <u>12</u> Month <u>20</u> Day <u>1957</u> Year		5. SEX <u>M</u> 6. COLOR OR RACE <u>W</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>Apr 7, 1892</u> 9. AGE (In years last birthday) <u>65</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cashier</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Wholesale Co.</u> 11. BIRTHPLACE (State or foreign country) <u>Mass.</u> 12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME <u>Wm Fletcher</u> 14. MOTHER'S MAIDEN NAME <u>Sarah</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> 16. SOCIAL SECURITY NO. <u>579-16-9304</u> 17. INFORMANT <u>Mrs Ruby L Fletcher</u> address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Blood pressure</u> (c) <u>3</u> DUE TO cause lost.		INTERVAL BETWEEN ONSET AND DEATH <u>2 hrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Had several Crivations and died as way to Hospital</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour o. m. p. m. 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>H W Ward</u> EXAMINER'S NAME (Type) 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 22b. DATE THEREOF <u>12-26-57</u> 22c. NAME OF CEMETERY OR CREMATORY <u>Wilmington Mt</u> 22d. LOCATION (City, town, or county) (State) <u>St. Marys Co.</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <u>12/20/57</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Lee Funeral Home Wash Dc</u> ADDRESS 24a. REC'D BY REGISTRAR <u>Dr. Hugh Ward</u> DATE <u>12 1957</u> 24b. REGISTRAR'S SIGNATURE			

RECEIVED

12919

CERTIFICATE OF DEATH

12912

Reg. Dist. No.

51

1. PLACE OF DEATH o. COUNTY <u>Calvert</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Calvert</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bowens</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>XO Bowens</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>1</u>	
3. NAME OF DECEASED (Type or print) First <u>Maqqie</u> Middle <u>L</u> Last <u>Gross</u>		4. DATE OF DEATH Month <u>12</u> Day <u>6</u> Year <u>1957</u>	
5. SEX <u>FF</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 30</u>
9. AGE (In years last birthday) <u>77</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Samuel Curtis</u>		14. MOTHER'S MAIDEN NAME <u>Christiana Harris</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Address <u>Wilson Gross, Adelina md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY OCCLUSION</u> <u>029X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>ARTERIOSCLEROSIS</u> DUE TO (c) <u>LUES</u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 hour</u> <u>12 yrs</u> <u>25 yrs +</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>MARCH 1937</u> to <u>DEC 6, 1957</u> that I last saw the deceased alive on <u>DEC 3, 1957</u> and that death occurred at <u>2 P. M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Page C. Jett</u> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED <u>PRINCE FREDERICK 12/9/57</u>	
PHYSICIAN'S NAME (Type) <u>PAGE C. JETT M.D.</u>			
22a. BURIAL CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>12-10-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Carrolls</u>	22d. LOCATION (City, town, or county) (State) <u>Barstow md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>P. E. Sewell Prince Frederick, Md</u>		24a. REC'D BY REGISTRAR <u>DATE 12-12-57</u>	24b. REGISTRAR'S SIGNATURE <u>H. W. Ward</u>

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 18

BUREAU V. S.

DEC 18 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12920 CERTIFICATE OF DEATH

1291351
 Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Calvert MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Calvert	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Prince Frederick		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Prince Frederick	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Calvert County Hospital		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Isaac Middle Harris Last 		4. DATE OF DEATH Month December Day 30 Year 1957	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Unknown
9. AGE (In years last birthday) 67 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY 	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Not known		14. MOTHER'S MAIDEN NAME Not Known	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No. (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 	
17. INFORMANT Lizzie Harris		Address Prince Frederick, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage 443x DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost. (b) Hypertensive c.v.d. DUE TO (c) 			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m. 	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Dec 26 , 1957, to Dec 30 , 1957, that I last saw the deceased alive on Dec 30 , 1957, and that death occurred at 11/4 M, from the causes and on the date stated above.			
ACTUAL SIGNATURE R. de Villars Reac		M.D. S. Therman DATE SIGNED 12/30	
PHYSICIAN'S NAME (Type) R. de VILLARS REAC M.D.			
22a. (BURIAL) CREMATION, REMOVAL (Specify) 1-2-58	22b. DATE THEREOF 1-2-58	22c. NAME OF CEMETERY OR CREMATORY Carnolls	22d. LOCATION (City, town, or county) (State) Barstow Md
23. FUNERAL DIRECTOR'S SIGNATURE P. E. Sewell		ADDRESS Prince Frederick	
24a. REC'D BY REGISTRAR Jan 3 1958		24b. REGISTRAR'S SIGNATURE Dr. Hugh Ward	

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

BUREAU V. S.

JAN 3 1953

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12921 CERTIFICATE OF DEATH

12914

Reg. Dist. No. 51

1. PLACE OF DEATH a. COUNTY <u>Calvert</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Calvert</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Prince Fred.</u>		c. LENGTH OF STAY IN TB		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Princess Frederick, Md</u>		d. STREET ADDRESS <u>1</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Benson</u> Middle <u>Hawkins</u> Last <u>Hawkins</u>				4. DATE OF DEATH Month <u>12</u> Day <u>6</u> Year <u>1957</u>			
5. SEX <u>m</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>march, 15</u>	9. AGE (In years last birthday) <u>60</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farm labor</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Robert Hawkins</u>				14. MOTHER'S MAIDEN NAME <u>Barbara Hicks</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>212-14-2530</u>		17. INFORMANT <u>Mrs. Nora Hicks Prince Fred, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized atherosclerosis</u> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Nov 1957</u> to <u>Dec 6, 1957</u> , that I last saw the deceased alive on <u>Dec 6, 1957</u> , and that death occurred at <u>9 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Rd de Villars</u> M.D.				ADDRESS (Street, city or town, state) <u>5+ Kennedy</u> DATE SIGNED <u>12/6</u>			
PHYSICIAN'S NAME (Type) <u>Rd de Villars</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>12-9-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Patuxent</u>		22d. LOCATION (City, town, or county) (State) <u>Huntingtown, Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>P. E. Sewell, Prince Fred, Md</u>				ADDRESS		24a. REC'D BY REGISTRAR DATE <u>12/9/57</u>	
						24b. REGISTRAR'S SIGNATURE <u>H. W. Ward</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form with multiple sections for recording death information, including fields for name, age, sex, race, cause of death, and place of death. The form is partially filled out with handwritten text.

BUREAU V. S.

DEC 11 1957

RECEIVED

RECEIVED
AUG 11 1957

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12915

12922 CERTIFICATE OF DEATH

Reg. Dist. No. 51

1. PLACE OF DEATH a. COUNTY <u>Calvert</u> MARYLAND		2. USUAL RESIDENCE where deceased lived. If institution: residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Calvert</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Prince Frederick</u>		c. LENGTH OF STAY IN 1b <u>4 yrs</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Calvert Co</u>		d. STREET ADDRESS <u>Md</u>	
3. NAME OF DECEASED (Type or print) <u>Kenneth James</u> First Middle Last		4. DATE OF DEATH <u>12</u> Month <u>22</u> Day <u>1957</u> Year	
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 20 1915</u>
9. AGE (In years last birthday) <u>41</u> yrs.		IF UNDER 1 YEAR <u>24</u> Months <u>2</u> Days <u>1</u> Hours <u>15</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Engineer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Md</u>	
11. BIRTHPLACE (State or foreign country) <u>Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John James</u>		14. MOTHER'S MAIDEN NAME <u>Freda Dupin</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>1-10-100000000</u>	
17. INFORMANT <u>Lucy James</u> Address <u>Calvert Co Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> DUE TO <u>Coronary atherosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>Malnutrition</u> DUE TO (c) <u>?</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Has had a cold for several days</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>H. W. Ward</u> M.D.		ADDRESS (Street, city or town, state) <u>Calvert Co Md</u> DATE SIGNED <u>12/24/57</u>	
PHYSICIAN'S NAME (Type) _____			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>12-23-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St Edmonds</u>	22d. LOCATION (City, town, or county) (State) <u>Tandeland Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>P. E. Sewell</u> ADDRESS <u>Pr. Fred, Md</u>		24a. REC'D BY REGISTRAR <u>H. W. Ward</u> DATE <u>12/24/57</u>	24b. REGISTRAR'S SIGNATURE

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE	
4. OCCUPATION		5. MARITAL STATUS		6. PLACE OF BIRTH	
7. DATE OF DEATH		8. TIME OF DEATH		9. PLACE OF DEATH	
10. CAUSE OF DEATH		11. MANNER OF DEATH		12. SIGNATURE OF PHYSICIAN	
13. SIGNATURE OF REGISTRAR		14. SIGNATURE OF WITNESSES		15. SIGNATURE OF CORONER	
16. SIGNATURE OF JURY		17. SIGNATURE OF JUDGE		18. SIGNATURE OF CLERK	
19. SIGNATURE OF SHERIFF		20. SIGNATURE OF DEPUTY SHERIFF		21. SIGNATURE OF CONSTABLE	
22. SIGNATURE OF JAILER		23. SIGNATURE OF WARDEN		24. SIGNATURE OF CHIEF CLERK	
25. SIGNATURE OF CHIEF OF POLICE		26. SIGNATURE OF DEPUTY CHIEF OF POLICE		27. SIGNATURE OF SQUAD LEADER	
28. SIGNATURE OF OFFICER		29. SIGNATURE OF DETECTIVE		30. SIGNATURE OF PATROLMAN	
31. SIGNATURE OF TRAFFIC OFFICER		32. SIGNATURE OF INVESTIGATOR		33. SIGNATURE OF IDENTIFICATION UNIT	
34. SIGNATURE OF LABORATORY		35. SIGNATURE OF MEDICAL EXAMINER		36. SIGNATURE OF PATHOLOGIST	
37. SIGNATURE OF ANATOMIST		38. SIGNATURE OF HISTOLOGIST		39. SIGNATURE OF RADIOLOGIST	
40. SIGNATURE OF CLINICAL PATHOLOGIST		41. SIGNATURE OF FORENSIC PATHOLOGIST		42. SIGNATURE OF TOXICOLOGIST	
43. SIGNATURE OF PHARMACOLOGIST		44. SIGNATURE OF MICROBIOLOGIST		45. SIGNATURE OF IMMUNOLOGIST	
46. SIGNATURE OF EPIDEMIOLOGIST		47. SIGNATURE OF PUBLIC HEALTH OFFICER		48. SIGNATURE OF HEALTH INSPECTOR	
49. SIGNATURE OF SANITARIAN		50. SIGNATURE OF NURSE		51. SIGNATURE OF DENTIST	
52. SIGNATURE OF VETERINARIAN		53. SIGNATURE OF CHINESE MEDICINE PRACTITIONER		54. SIGNATURE OF AYURVEDIC PRACTITIONER	
55. SIGNATURE OF HOMEOPATHIC PRACTITIONER		56. SIGNATURE OF NUTRITIONIST		57. SIGNATURE OF DIETITIAN	
58. SIGNATURE OF PHYSIOLOGIST		59. SIGNATURE OF PSYCHOLOGIST		60. SIGNATURE OF PSYCHIATRIST	
61. SIGNATURE OF NEUROLOGIST		62. SIGNATURE OF ORTHOPEDIC SURGEON		63. SIGNATURE OF PEDIATRIC SURGEON	
64. SIGNATURE OF OBSTETRICIAN		65. SIGNATURE OF GYNCOLOGIST		66. SIGNATURE OF UROLOGIST	
67. SIGNATURE OF OPHTHALMOLOGIST		68. SIGNATURE OF ENT AURAL NOSE AND THROAT SPECIALIST		69. SIGNATURE OF RADIATION PHYSICIAN	
70. SIGNATURE OF RADIOLOGIC PHYSICIAN		71. SIGNATURE OF RADIOLOGIC PHYSICIAN		72. SIGNATURE OF RADIOLOGIC PHYSICIAN	
73. SIGNATURE OF RADIOLOGIC PHYSICIAN		74. SIGNATURE OF RADIOLOGIC PHYSICIAN		75. SIGNATURE OF RADIOLOGIC PHYSICIAN	
76. SIGNATURE OF RADIOLOGIC PHYSICIAN		77. SIGNATURE OF RADIOLOGIC PHYSICIAN		78. SIGNATURE OF RADIOLOGIC PHYSICIAN	
79. SIGNATURE OF RADIOLOGIC PHYSICIAN		80. SIGNATURE OF RADIOLOGIC PHYSICIAN		81. SIGNATURE OF RADIOLOGIC PHYSICIAN	
82. SIGNATURE OF RADIOLOGIC PHYSICIAN		83. SIGNATURE OF RADIOLOGIC PHYSICIAN		84. SIGNATURE OF RADIOLOGIC PHYSICIAN	
85. SIGNATURE OF RADIOLOGIC PHYSICIAN		86. SIGNATURE OF RADIOLOGIC PHYSICIAN		87. SIGNATURE OF RADIOLOGIC PHYSICIAN	
88. SIGNATURE OF RADIOLOGIC PHYSICIAN		89. SIGNATURE OF RADIOLOGIC PHYSICIAN		90. SIGNATURE OF RADIOLOGIC PHYSICIAN	
91. SIGNATURE OF RADIOLOGIC PHYSICIAN		92. SIGNATURE OF RADIOLOGIC PHYSICIAN		93. SIGNATURE OF RADIOLOGIC PHYSICIAN	
94. SIGNATURE OF RADIOLOGIC PHYSICIAN		95. SIGNATURE OF RADIOLOGIC PHYSICIAN		96. SIGNATURE OF RADIOLOGIC PHYSICIAN	
97. SIGNATURE OF RADIOLOGIC PHYSICIAN		98. SIGNATURE OF RADIOLOGIC PHYSICIAN		99. SIGNATURE OF RADIOLOGIC PHYSICIAN	
100. SIGNATURE OF RADIOLOGIC PHYSICIAN		101. SIGNATURE OF RADIOLOGIC PHYSICIAN		102. SIGNATURE OF RADIOLOGIC PHYSICIAN	

BUREAU V. S.

DEC 26 1957

RECEIVED

12923 CERTIFICATE OF DEATH

Reg. Dist. No. 202

1. PLACE OF DEATH a. COUNTY <u>Calvert</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Calvert</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Prince Frederick</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x2 Luby Luby</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>C</u> Last <u>Tarbee</u>				4. DATE OF DEATH Month <u>Dec</u> Day <u>14</u> Year <u>1957</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March 24, 1868</u>	
9. AGE (In years last birthday) <u>89</u> yrs.		IF UNDER 1 YEAR Months <u>8</u> Days <u>19</u>		IF UNDER 24 HRS. Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Dean Dawson</u>				14. MOTHER'S MAIDEN NAME <u>Mary Purcell</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>-</u>				16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT Address <u>Hospital Record</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1 Coronary occlusion</u> DUE TO (b) <u>Generalized arteriosclerosis</u> DUE TO (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>Dec 13, 1957</u> to <u>Dec 13, 1957</u> , that I last saw the deceased alive on <u>Dec 13, 1957</u> , and that death occurred at <u>8</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>[Signature]</u> M.D.				ADDRESS (Street, city or town, state) <u>5x Leonard</u> DATE SIGNED <u>12/14</u>			
PHYSICIAN'S NAME (Type) <u></u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/16/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Ebenezer</u>		22d. LOCATION (City, town, or county) (State) <u>Great Mills, Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. Clarke Mattingley</u> ADDRESS <u>Leonardtown, Md</u>				24. REC'D BY REGISTRAR <u>12/16/57</u>		24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

BUREAU V. S.

DEC 18 1957

RECEIVED

INSTRUCTIONS

1 TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician, and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

Item 7 FilmG223 12-17-57 et

12917

12924

CERTIFICATE OF DEATH

Reg. Dist. No. 52

1. PLACE OF DEATH COUNTY <u>Calvert</u> MARYLAND CITY OR TOWN <u>Prince Frederick</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Calvert Co Hospital</u>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>MD</u> COUNTY <u>Chc</u> CITY OR TOWN <u>San Haven</u> STREET ADDRESS <u>MD</u>	
3. NAME OF DECEASED (Type or Print) <u>Charles F. Leatherman</u> (First) (Middle) (Last)		4. DATE OF DEATH Month <u>12</u> Day <u>5</u> Year <u>1957</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>Aug. 26, 1915</u>
9. AGE last birthday <u>42</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Caretaker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>West Virginia</u>	
11. BIRTHPLACE (State or foreign country) <u>West Virginia</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Leatherman</u>		14. MOTHER'S MAIDEN NAME <u>Weller</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO. <u>219-30-9603</u>	
17. INFORMANT & ADDRESS <u>Mrs Ernest McNeil Wash. D.C.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 331X IMMEDIATE CAUSE (A) <u>Cerebral hemorrhage</u>		18. MEDICAL CERTIFICATION <u>Was found unconscious at 11 AM</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>6 hrs</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u></u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u></u>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS (OF OPERATION)	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (M. M. Not while at work <input type="checkbox"/> While at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>12/5</u> , 19 <u>57</u> , to <u>12/5</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>12/5</u> , 19 <u>57</u> , and that death occurred at <u>3:30 PM</u> , from the causes and on the date stated above.			
SIGNATURE <u>H. W. Ward</u>		ADDRESS (Street, city, town, state) <u>Friendship Md</u> DATE SIGNED <u>12/11/57</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Buried</u>		DATE THEREOF <u>12-8-57</u>	
NAME OF CEMETERY OR CREMATORY <u>Friendship</u>		LOCATION (City, town, or county) (State) <u>Friendship Md</u>	
24. REC'D BY REGISTRAR <u>Trace L. Kutchinski</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Trace L. Kutchinski</u>	
DATE <u>12/17/57</u>		ADDRESS <u>Friendship Md</u>	

CERTIFICATE OF DEATH

1957

REG. NO. 112

C. USUAL AND USUAL HOME OR OTHER PLACE

MARYLAND

CITY OF BALTIMORE

WARD 1

STREET

APARTMENT

ROOM

FLOOR

SECTION

LOT

BLK.

TRACED

DEPT.

OFFICE

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12925

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Calvert</i> b. CITY OR TOWN (If outside corporate limits, write nearest town) <i>Huntington</i> c. LENGTH OF STAY IN 1b <i>Life</i> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <i>Md</i> b. COUNTY <i>Calvert</i> c. CITY OR TOWN (If outside corporate limits, write nearest town) <i>Huntington</i> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Walter First Middle Last</i> 4. DATE OF DEATH Month <i>12</i> Day <i>27</i> Year <i>1957</i>		5. SEX <i>M</i> 6. COLOR OR RACE <i>W</i> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <i>Jan 1, 1892</i> 9. AGE (In years last birthday) <i>65</i> yrs. IF UNDER 1 YEAR Months <i>11</i> Days <i>26</i> IF UNDER 24 HRS. Hours <i></i> Min. <i></i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Farmer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Farming</i> 11. BIRTHPLACE (State or foreign country) <i>Md</i> 12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Reagan Hammond Shelt</i>		14. MOTHER'S MAIDEN NAME <i>Carrie B. Watson</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>yes</i> (If yes, give date of discharge)		16. SOCIAL SECURITY NO. <i>?</i> 17. INFORMANT <i>Angie Shelt</i> Address <i></i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Caducal failure</i> <i>782.4</i> DUE TO Conditions, if any, which gave rise to immediate cause (b) <i></i> (c) <i></i> DUE TO (a), stating the underlying cause last. <i></i> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Found dead in his house</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>A. W. Ward</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <i>H. W. WARD</i>		DATE SIGNED <i>12/27/57</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <i>Dec. 29, 1957</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Miranda Cemetery</i>	22d. LOCATION (City, town, or county) (State) <i>Huntington Md</i>
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <i>A. A. Hackman & Son - Mutual, Ind.</i>		24. REC'D BY REGISTRAR DATE <i>31 1957</i>	24. REGISTRAR'S SIGNATURE <i>Hugh Hardy</i>

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be for the use of the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

BUREAU V. S.

DEC 31 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12926

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12919 51

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Calvert</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lusby</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				2. USUAL RESIDENCE (Where deceased lived. If Institution, residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Calvert</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>XO Lusby</u> d. STREET ADDRESS <u>1</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Robin</u> First <u>Oct Cecilia</u> Middle <u>Taylor</u> Last				4. DATE OF DEATH Month <u>12</u> Day <u>31</u> Year <u>1957</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov 23, 1957</u>		9. AGE (In years last birthday) <u>7</u> yrs.	IF UNDER 1 YEAR Months <u>7</u> Days <u>7</u>	IF UNDER 24 HRS. Hours <u>7</u> Min. <u>19</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MD</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Warren Taylor</u>				14. MOTHER'S MAIDEN NAME <u>Catherine Smith</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Warren Taylor Lusby</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory infection</u> 527.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Found dead in bed 5 AM, bedstead etc.</u>						INTERVAL BETWEEN ONSET AND DEATH	
19a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		19b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
22a. BURIAL, CREMATION, REMOVAL (Specify)				22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY	
				<u>1-1-58</u>		<u>St. Johns</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>P. E. Sewell Prince Frederick, Md</u>				ADDRESS		24a. REC'D BY REGISTRAR	
						24b. REGISTRAR'S SIGNATURE <u>Dr. Hugh Hardy</u>	

2064181XV5

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12927

CERTIFICATE OF DEATH

Reg. Dist. No.

12927

1. PLACE OF DEATH a. COUNTY <u>Calvert</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Calvert</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Princess Frederick</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Calvert Beach</u> x2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Calvert County Hospital</u>		d. STREET ADDRESS <u>St. Leonard, Md.</u>	
3. NAME OF DECEASED (Type or print) <u>Carl</u> <u>A.</u> <u>Vogle</u>		4. DATE OF DEATH Month <u>Dec.</u> Day <u>30</u> Year <u>1957</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 28 1890</u> 67 yrs.
9. AGE (In years last birthday) <u>67</u>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Self Employed</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Apartment House</u>	
11. BIRTHPLACE (State or foreign country) <u>Hungary</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. C.</u>	
13. FATHER'S NAME <u>Joseph Vogle</u>		14. MOTHER'S MAIDEN NAME <u>?</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>502-09-0412</u>	
17. INFORMANT <u>Anna Vogle</u>		Address <u>Calvert Beach</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY OCCLUSION</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ant. sclerotic C.V. disease</u> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> <u>2 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Aug 14</u> , 19 <u>57</u> , to <u>Dec 30</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Dec 30</u> , 19 <u>57</u> , and that death occurred at _____ M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Page Pitt</u>		ADDRESS (Street, city or town, state) <u>PRINCE FREDERICK</u>	
PHYSICIAN'S NAME (Type) <u>PAGE C. JETT</u>		DATE SIGNED <u>1/1/57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Jan. 2, 1958</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Washington D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>A. G. Harkness & Son - Mutual, Md.</u>		24a. REC'D BY REGISTRAR <u>DATE 3 1958</u>	
24b. REGISTRAR'S SIGNATURE <u>Dr. Hugh Hardy</u>			

